

**STATE OF MICHIGAN**

**GOVERNOR'S TASK FORCE ON CHILDREN'S JUSTICE**

**Munchausen By Proxy**

**A Collaborative Approach  
to Investigation, Assessment  
and Treatment**

**GOVERNOR'S TASK FORCE ON CHILDREN'S JUSTICE**



**STATE OF MICHIGAN**  
**Department of Human Services**

## CURRENT TASK FORCE MEMBERS

### **Honorable Justice Elizabeth A. Weaver**

Michigan Supreme Court  
Chairperson of Task Force

### **Sherry Amen-Bryan**

*ACCESS Psychologist  
Wayne County*

### **Wayne Beerbower**

*Retired Farmington Hills Police Officer,  
Police Officers Association of Michigan*

### **Nancy J. Diehl**

*Chief Prosecuting Attorney,  
Felony Trial Division,  
Wayne County Prosecutor's Office*

### **Honorable Susan Dobrich**

*Cass County Probate Court  
Chief Judge*

### **Sydney Duncan**

*Family Advocate  
Wayne County*

### **Shauna Dunnings**

*Friend of the Court  
Ingham County*

### **Donald N. Duquette**

*Child Advocacy Law Clinic, Director  
University of Michigan Law School*

### **Elias Escobedo, Jr.**

*Attorney  
Oakland County*

### **Honorable Nancy Francis**

*Probate Court Judge  
Washtenaw County*

### **Honorable Pamela G. Gilbert-O'Sullivan**

*Macomb County Probate Court  
Chief Judge*

### **Gloria Gillespie**

*Assault Recovery Associates  
St. Joseph*

### **Sheriff John Gravier**

*Ontonagon County*

### **Honorable Linda S. Hallmark**

*Probate Court Judge  
Oakland County*

### **Honorable Judy Hartsfield**

*Probate Court Judge  
Wayne County*

### **Radwan Khoury**

*Executive Director, Arab-American &  
Chaldean Council  
Wayne County*

### **Kathleen A. Kovalchik-Lacko**

*West Michigan Child and Family  
Leadership Council  
Mason County*

### **Judith Labovitz**

*Public Representative  
Ingham County*

### **William Lansat**

*Defense Attorney  
Oakland County*

**Sandra Lindsey**

*Executive Director of the Saginaw  
County Mental Health Authority  
Saginaw County*

**Mark Liss**

*Assistant Deputy City Attorney  
City of Royal Oak  
Oakland County*

**Christine M. McPherson**

*ACFS Division Director, Anishnabek  
Community and Family Services  
Sault Ste. Marie Tribe of Chippewa  
Indians*

**Rev. Theodore C. Melinat**

*Retired Executive Director  
Lutheran Child and Family Services of  
Michigan*

**JoAnn C. Monaghan**

*Retired Principal  
Port Huron Area School District*

**Honorable Eugene Moore**

*Probate Court Judge  
Oakland County*

**Jolanda Murphy**

*Department of Justice Manager,  
Grand Traverse Band of Ottawa &  
Chippewa Indians  
Leelanau County*

**Robert O'Brien**

*Director of Partnership Development  
for Southwest Solutions  
Wayne County*

**Euphemia Parrish**

*Executive Director  
South Eastern Michigan Indians, Inc.  
Wayne County*

**Honorable Gregory Pittman**

*Probate Court Judge  
Muskegon County*

**Michael Reisch**

*Professor at University of Michigan  
Washtenaw County*

**Sheriff Lawrence Richardson**

*Lenawee County*

**Patricia Sorenson**

*Michigan's Children  
Ingham County*

**Honorable Lisa Sullivan**

*Clinton County Probate Court  
Chief Judge*

**Alice Thompson**

*CEO of the Black Family Development  
Inc.  
Wayne County*

**Marianne Udow**

*DHS Director  
Lansing*

**Patricia Wagner**

*CASA Representative  
Ingham County*

**David Wolock**

*Attorney  
Oakland County*

**Tracey Yokich**

*Sixteenth Judicial Circuit Court Judge,  
Macomb County*

**TASK FORCE STAFF SUPPORT DEPARTMENT OF HUMAN SERVICES (DHS)**

**Colleen Duhm**

*Children's Protective Services*

**Ted Forrest**

*Program Manager*

*Children's Protective Services*

**Jim Hennessey**

*Deputy Director*

*Children's Services*

**Mary Mehren**

*Manager*

*Children's Protective Services & Foster Care*

**Steve Yager**

*Manager*

*Office of the Family Advocate*

**MUNCHAUSEN BY PROXY COMMITTEE**

**Donald N. Duquette, Chair**

**Dr. Joseph F. Marshall**

**Ted Forrest**

**Ernestine Moore**

**Gloria Gillespie**

**Rev. Theodore C. Melinat**

**William Lansat**

**Dr. Dennis Smallwood**

**ADVISORS**

**Howard Fischer, M.D.**  
*Wayne State University*  
*Department of Pediatrics*  
*Children's Hospital of Michigan*

**Patricia T. Siegel, Ph.D.**  
*Wayne State University*  
*School of Medicine*  
*Department of Psychiatry and Behavioral*  
*Neurosciences, Pediatrics*  
*Children's Hospital of Michigan*

**PRINCIPAL AUTHORS**

**Donald N. Duquette**  
**and**  
**Patricia T. Siegel**

**MUNCHAUSEN BY PROXY**  
(PEDIATRIC CONDITION FALSIFICATION and  
FACTITIOUS DISORDER BY PROXY)

**A COLLABORATIVE APPROACH TO INVESTIGATION,  
ASSESSMENT AND TREATMENT**

**PART ONE**

**INTRODUCTION**

**A. PURPOSE**

The purpose of this publication is to present a multidisciplinary approach that guides various professional through detection, investigation, legal proceedings, and treatment of phenomena generally called Munchausen by Proxy (MBP). Identifying and responding to this unusual and complex form of child abuse requires a carefully coordinated multidisciplinary intervention. This document is not a substitute for each professional being knowledgeable about MBP from the perspective of his or her own discipline. Rather, this publication is meant to serve an integrative and coordinating function to help each professional understand his or her role in the context of the others. A list of selected references is included at the end of this document.

**B. DEFINITION**

The term "Munchausen by Proxy" (MBP) is used to describe a form of child abuse in which a parent, nearly always a mother, over-reports symptoms or illness or cause unnecessary medical procedures to be performed on the child. The psychological and medical literature describes "inducers" who directly cause the child's illness, and "fabricators" who exaggerate their child's symptoms to get medical attention and treatment.<sup>1</sup> Because the parents may have some degree of medical training or knowledge about child development/behavior, they are able to present a convincing, but deceptive medical history that persuades physicians to perform unnecessary medical procedures. Thus, physicians may become unwitting facilitators by performing unnecessary surgeries, diagnostic procedures, and other medical treatment based upon the parent's false or exaggerated reports.

In 1998 the American Professional Society on the Abuse of Children (APSAC) reported that the constellation of behaviors generally referred to as Munchausen by Proxy actually includes a pediatric diagnosis of child abuse and a psychiatric diagnosis of the perpetrator.<sup>2</sup> Thus Munchausen by Proxy consists of two perspectives - the pediatric and the psychological; the victim's and the perpetrator's. From the perspective of the child victim, the diagnosis is **Pediatric Condition Falsification (PCF)** and is defined as "a form of child maltreatment in which an adult falsifies physical and/or psychological signs and/or symptoms in a victim, causing the victim to be regarded as ill or impaired by others."<sup>3</sup> From the perspective of the perpetrator, the diagnosis is **Factitious Disorder by Proxy (FDP)** and is defined as "a psychiatric disorder which is applied to a person who intentionally falsifies signs or symptoms in a victim (usually, but not always, a child)."<sup>4</sup> The confluence of PCF and FDP constitutes Munchausen by Proxy

(MBP). This publication uses the general term, Munchausen by Proxy, to refer to this behavior. Finally, Munchausen by Proxy has been described as a family disorder in which non-perpetrating spouses, parents and others may support and participate in the deception that is at the core of the perpetrating parent's victimization of the child. The entire family dynamic must be considered in the assessment and treatment process.<sup>5</sup>

The psychological mechanisms that motivate a parent to harm a child in this way seem varied, even though the result, unnecessary medical evaluations and/or treatment, remains the same. One view is that the need for attention and being perceived as the devoted parent of a sick child is the primary motivating factor. Or, a parent may have a psychological need to deceive physicians or other authority figures. Alternatively, an over-anxious and emotionally disturbed parent may exaggerate a child's medical condition as a misguided ruse to get attention from the physicians. Other possible dynamics include a maladaptive coping strategy linking love and illness or reflecting a life-long pattern of a pathological attitude toward illness. Finally, family factors such as paternal disengagement or a profound lack of empathy because of a personal history of abuse might explain the behavior.<sup>6</sup>

Professionals must be diligent so children suffering this form of child abuse are identified and protected. On the other hand, care must be taken to distinguish Munchausen by Proxy from a case of a parent with mental illness or limited capacity or a parent with exaggerated but sincere concern for their child's health. It is normal for parents to be concerned when their children are ill. Certain children are vulnerable and in need of extensive medical care because of a past medical history of real life-threatening illness. Care must be taken to distinguish an anxious, or overly anxious parent who may be responding to a seriously ill child, from a parent who persistently engages in abusive, pathological health seeking behaviors and manipulates well-meaning medical professionals as instruments of child abuse by persuading them to perform unwarranted, unneeded and potentially dangerous medical procedures on a child.

### **C. EFFECTS ON CHILD**

The impact of MBP on the child-victim may include physical, emotional, and psychological harm. Child-victims may experience deterioration of an existing medical condition because of deliberate non-adherence to treatment for a genuine illness or may acquire medical problems from the invasive diagnostic procedures and/or surgeries ordered by unwitting physicians. Nearly all of these child-victims suffer at least short-term harm, may suffer significant long-term or permanent disability from their maltreatment and some die.<sup>7</sup> Emotional and psychological effects are also common and may be nearly as devastating as the physical effects. One of the most profound psychological effects is the violation of trust in the parent-child relationship as the child gets older. There is also a significant financial cost because of the unnecessary medical tests and procedures ordered and invested time of health care providers. Lastly, recent work suggests that there is an increased risk for Munchausen's syndrome in an adult who had been a child victim of MBP.<sup>8</sup>

### **D. SCOPE OF THE PROBLEM**

There is no firm data on the incidence of this phenomenon. A recent study in the United Kingdom reported an estimated annual incidence of 3 per 100,000 young children victimized by this form of abuse.<sup>9</sup> A recent article suggests that a minimum of 600 new cases of just two forms of MBP, suffocation and non-accidental poisoning, are identified in the USA each year.<sup>10</sup> The true incidence remains unknown, however, because MBP abuse involves deception and the professional community only know about and report those cases where the deception fails. There may be many more cases that go undetected.

## **E. MULTIDISCIPLINARY COORDINATION AND COLLABORATION IS ESSENTIAL**

Coordination and collaboration of several disciplines and agencies is essential for identifying and responding to cases of suspected MBP. Each discipline should approach MBP cases from its own area of expertise with the common goal of ensuring the safety of the victims. Each discipline has a unique perspective and reaction to MBP and this publication attempts to describe the role of each and the manner in which the various professions must coordinate and interact. Each will be discussed in turn.

The document is organized along the time continuum common to detection and management of these cases. Part Two addresses Detection, Part Three Investigation and Assessment, Part Four the Court Process, and Part Five addresses the Treatment Phase and Possible Reunification. Endnotes and a Bibliography complete the document. The responsibilities of the various professionals along this time continuum are summarized in Chart #1, *Professional Coordination in Suspected Munchausen by Proxy Cases*.

**CHART #1, PROFESSIONAL COORDINATION IN SUSPECTED MUNCHAUSEN BY PROXY CASES**

	<b>Detection</b>		<b>Investigation and Assessment</b>			<b>Court</b>
<b>Physician/ Medical Team</b>	Evaluate health seeking. Review applicable medical records. pp. 6-7	If child abuse or neglect is suspected, refer to CPS. p. 7	Notify MBP consultant. Begin formal assessment. p. 9	Consider planned hospitalization. p. 9	Make diagnosis, direct further eval OR rule out. p. 10	Testify re medical history. Medical records review underway. p. 16
<b>DHS Children's Protective Services/ Foster Care</b>		Complaint Received. p. 8	Meet with physician or medical team. p. 8	Refer to medical review if not done already. Obtain needed medical records. p. 10	If barriers to obtaining medical records, petition court for order to release records. pp. 10-11	File Petition; make placement recommendation. Ensure that placement is safe and consistent with need of child. Consider protective orders that control parent access to child, protect siblings. p. 13
<b>Court</b>					If requested, consider entering orders for investigation or emergency placement. pp. 10-11	Preliminary Hearing; determine whether child abuse is supported by probable cause. Determine placement pending trial and, if placed, parenting time. Order further investigation, including psychological evaluation. pp. 15-17
<b>The county prosecutor or Attorney General)</b>					Assist in discovery of records. pp. 10-11	Draft and file petition; meet with medical team to prepare testimony. Present case to the court. If petition is authorized, ask for placement that keeps child safe. Ask court to order psychological evaluation. pp. 15-17
<b>L-GAL</b>						Appointed. Meet child and fulfill statutory duties. Keep focused on needs of the child. Keep court focused on timeline. pp. 13-14
<b>Lawyers for Parent(s)</b>			Evaluate case. p. 14	Determine whether to meet with CPT and CPS, identify concerns and address outside of court OR to resist. p. 14	Identify knowledgeable and objective experts in medicine or psychology or both. Recommend evaluation without court action. p. 14	Carefully review medical history. Challenge and justify when possible. Keep child and parents together as much as possible. Be sure evaluator is objective and competent. pp. 16-17
<b>Forensic Psychologist</b>						Upon court ordering evaluation, obtain background information from CPS and schedule interviews. pp. 11-12
<b>Treatment Team</b>						

Process			Treatment Phase	
Independent non-treating physicians complete medical records review p. 11	Testify. p. 18	Update on medical condition of child. p. 18	Provide ongoing medical care and treatment for the child. p. 19	Provide ongoing medical care and treatment for the child. p. 19
All medical records obtained. Request court order for forensic psychological evaluation. p. 18	Provide testimony. Assist in organizing medical witnesses. p. 18	Foster Care Worker develops ISP/Case Plan. pp. 18-19	Obtain needed services. Monitor home visits. Report to Court. p. 19	Monitor compliance with treatment/court orders; child's adjustment to foster care; child's medical care. p. 20
Pre-Trial. Discovery, Plea? If not, set trial date. Set pretrial schedule. p. 17	Trial. Before judge or jury, is child abuse or neglect established by preponderance of evidence? p. 18	Disposition. Evaluate medical and psychological evidence. Set treatment plan and order compliance. Reconsider child's placement. pp. 18-19	Review hearings. Monitor progress. Modify treatment plan as evidence warrants. pp. 18-21	Permanency Plan. Order return home, set for TPR hearing, or establish alternative. pp. 18-21
Ensure discovery is completed on time. Try to settle. Determine needs for trial. p. 18	Present case for jurisdiction. p. 18	Present DHS plan for disposition, as informed by psych. eval. and medical team. pp. 18-19	Present DHS recommendations. pp. 18-21	Present DHS recommendations. pp. 18-21
Ensure child is safe and that all discovery needed for trial is completed. Settle? p. 18	Represent child's interests at trial. p. 18	Present plan for disposition (joint with DHS if appropriate). pp. 18-19	Monitor closely. Visit child. Focus on long-term plan. pp. 18-21	Monitor closely. Visit child. Make permanency recommendation. pp. 18-21
Settle? Prepare for trial. Obtain placement if possible to parents or family. p. 18	Represent parent(s) zealously at trial. p. 18	Harmonize disposition with needs of parents. pp. 18-19	Encourage full cooperation for early return or dismissal. Keep placement in extended family if possible. pp. 18-21	Encourage full cooperation for early return or dismissal. Keep placement with parents or in extended family. pp. 18-21
Review summary of medical record review. Evaluate family. p. 18	Complete assessment; possible testify. p. 18	Written report or testimony is key to disposition and treatment. pp. 19-20	Communicate closely with other treaters. DHS parents and child. pp. 18-21	Re-evaluate family, make recommendations regarding reunification. pp. 18-21
		Accepts court findings. Experience in personality disorders/ child abuse. pp. 18-21	Start treatment as soon as possible. Underlying dynamics must be understood. pp. 18-21	Make progress report and recommendations for failure treatment. pp. 18-21

## PART TWO

### DETECTION

#### A. WARNING SIGNS OF PATHOLOGICAL HEALTH SEEKING BEHAVIOR

Although family members, neighbors, teachers and others may report pathological use of health care to child protective services, it is usually a physician who is in a position to initially suspect pathological health seeking behavior. Detection is subtle and dependent on swift recognition of the warning signs that should trigger suspicion. These warning signs are not diagnostic on their own and are not necessarily exclusive to MBP abuse. However, when several warning signs exist, the physician needs to recognize that the child is at risk of harm and the physician should include MBP abuse in the differential diagnosis and evaluate that possibility. These warning signs, when clustered together, raise the chances that the child is at risk. Specific warnings signs fall into several domains:<sup>11</sup>

##### Illness Related Warning Signs

- Unexplained/recurrent/prolonged illness leading to several hospitalizations and multiple medical procedures.
- Discrepancy between reported history, clinical assessment and laboratory results.
- Discrepancy between child's appearance and reported medical history.
- Symptoms are often vague and lack verifying signs.
- Symptoms only occur or are reported to occur in offending parent's presence.
- Poor response to standard treatment.
- Bizarre, unusual laboratory results.
- Prior concerns of MBP in medical records.

##### Perpetrator Warning Signs

- Intense desire to maintain close relationship with medical staff.
- Immediate acceptance of recommendations for invasive, painful procedures.
- Failure to express relief when presented with negative test findings.
- Strong resistance to having child discharged.
- Presents as more interested in the medical condition than in the child; parent's affect is not consistent with the severity of the symptoms described.
- Reports numerous dramatic life events.

##### Parent-Child Relationship Warning Signs

- Excessive attention in the form of enmeshment, overprotection, restriction of activities and relationships.
- Offending parent insists on doing routine medical/nursing care in hospital.
- Child's symptoms diminish or cease when away from suspected parent.
- Child responds to standard medical treatment when away from suspected parent.
- Older children colluding with the suspected parent.
- Younger children appear to have a passive tolerance of painful procedures.

### Family Indicator Warnings Signs

- Unexplained sibling illness or death.
- Marital discord.
- Absent or disengaged father.
- History of physical or sexual abuse in suspected parent's family of origin.

## **B. INITIATING FORMAL MEDICAL ASSESSMENT OF PATHOLOGICAL HEALTH SEEKING BEHAVIORS**

Because Munchausen by Proxy is a medical child abuse and a pediatric diagnosis, the responsibility for initiating the formal assessment process in order to make the diagnosis initially rests with health care providers. Pediatricians or family physicians can independently begin the assessment but, as in other types of child abuse, an assessment process completed by a multidisciplinary team that includes the primary treating physician and other consultants and specialists is preferred. When a Child Protection Team (CPT) is available, it should be consulted to guide the assessment process. If, at any point in the medical assessment process, the treating physician or any other member of the medical team have "reasonable cause to suspect child abuse or neglect" he or she should make a report immediately to Children's Protective Services (CPS) as required by law.<sup>12</sup> The CPS worker, in turn, should begin the investigation including contacting and collaborating with the medical team as they complete the medical assessment.

Whether done by an individual physician, multidisciplinary medical team, a hospital-based CPT or by health care providers working together in another structure, the first task is to determine if there is a gross discordance between the suspected parent's health-seeking behaviors and the child's true medical condition. The physician and his or her team should consider asking a number of the following questions:

1. How much discordance is there between the physician's clinical assessment of the child's condition and the suspected parent's description of the condition?
2. Is there objective evidence (e.g., positive test results) that the child has a medical illness?
3. Is there evidence of false medical history or false psychosocial history reported by the suspected parent that is shown to be untrue by other reliable sources?
4. Has treatment for the child been based on the physician's clinical impressions or because of the suspected parent's reports of the child's symptoms and because of the parent's persistent demands?
5. Is there objective test data to support treatment recommendations or is treatment primarily determined by the medical history provided by the suspected parent?
6. Has any member of the medical staff seen the child's symptoms from their onset?
7. Does the suspected parent appear to thrive on interacting with medical staff and mentoring parents of other ill children?
8. Have other family members verified any of the child's symptoms when asked without the suspected parent present?
9. Has the child failed to respond to several standard medical treatments?
10. Does the suspected parent adamantly refuse to accept reassurance that the child's illness is not serious?
11. Does the suspected parent inappropriately resist having the child discharged?
12. Does the suspected parent insist on more tests and/or treatments?

In determining whether Munchausen by Proxy is present, a review of the medical history is critical. The treating physician or a selected member of the medical team should complete a careful review of the child's available medical records. Phone calls to other health care providers and the child's teacher/school are also helpful at this juncture. If the medical record review summary provides further support for a diagnosis of MBP, the child is at risk for continued harm and, if not already done, child protective services should be alerted. If court action has not already begun, it should be initiated at this point.

## **PART THREE**

### **INVESTIGATION**

#### **A. CHILDREN'S PROTECTIVE SERVICES**

The Investigation stage begins at the point that the treating physician, the multidisciplinary medical team, or any other person has "reasonable cause to suspect child abuse or neglect" and makes a report of suspected child abuse or neglect to Children's Protection Services are required by law.<sup>13</sup> The investigation stage is primarily a matter of CPS but the medical treatment team or suspecting physician(s), continue to play a critical role. CPS will manage and facilitate the investigation. CPS will coordinate the medical assessment, facilitate obtaining medical and other records regarding the child and the family, request a forensic psychological evaluation of the suspected parent and child-victim, consult with legal counsel, and initiate legal proceedings if required to protect the child or to further the investigation. Using the Department of Human Services CPS Safety Assessment, the worker will evaluate the case for safety of the child and may recommend placement. The CPS worker should be experienced in MBP abuse, or be supervised by someone who is, or have expert consultation available by phone or in person. CPS involvement is generally initiated before sufficient evidence to show probable cause has been developed. CPS may delay the notification of the person responsible for the child's health or welfare of the allegations if that notification would compromise the safety of the child or the child's siblings or the integrity of the investigation.<sup>14</sup> CPS is required to seek the assistance of and cooperate with law enforcement officials within 24 hours after becoming aware that abuse or neglect resulting in severe physical injury to a child requires medical treatment or hospitalization.<sup>15</sup>

In all cases the CPS worker will cooperate with the medical team as they complete the medical assessment. In any case where Child Protective Services receives a report of suspected MBP abuse from a physician or other qualified professional, CPS should request a medical assessment, including a medical record reviewed by a pediatrician experienced in Munchausen by Proxy abuse. When MBP is suspected, CPS should obtain a medical assessment even in cases where it appears the department may be able to prove that the child is harmed. Unless full medical and psychological evaluations of parents and child are already underway. CPS should engage competent and experienced experts to do so. Neither the medical record reviewer nor the evaluating-forensic psychologist should be part of the medical team that provided treatment to the patient and/or made the MBP report to CPS. Keeping these roles separate should assure that the evaluation is done objectively, competently, carefully and in full compliance with best medical standards.

DHS is generally able to get all necessary background reports and medical records to the medical team. Cooperation with DHS in a suspected child abuse or neglect investigation provides the participating hospitals and professional with immunity.<sup>16</sup> CPS should contact legal counsel for legal advice and guidance, help in obtaining reports, and to get assistance in preparing any necessary testimony for Preliminary Hearing.

## B. MEDICAL ASSESSMENT

Although the medical information may warrant a report of suspected child abuse or neglect based on a “reasonable cause to suspect child abuse or neglect”, the data may not be sufficient to confirm or exclude a medical diagnosis of Munchausen by Proxy abuse. In that case, further medical evaluation is necessary and a multidisciplinary case conference including all involved professionals should be convened to develop an agreed upon method to comprehensively assess the suspected parent’s health seeking behaviors. A physician experienced in MBP abuse can serve as the coordinator of the case conference and also can assume a crucial role as the liaison between the child protection agency, the court and the medical system. The existence of one or more physicians who may actively support the suspected parent or who hold a unique medical theory about the child’s condition that is not credible to other physicians treating the family should not be grounds for aborting further medical assessment. In many cases, parents who engage in this form of abuse are effective at rallying allies or locating one or more physicians who are vulnerable to their deceptions or willing to entertain very far-fetched theories rather than accept the possibility of intentional deception.

Three options may be considered to comprehensively assess pathological health seeking behaviors or MBP abuse - Planned Hospitalization, Covert Video Surveillance and Temporary Diagnostic Separation.<sup>17</sup> Each of these will be discussed in turn.

*Planned hospitalization* may be the latest restrictive method to establish the relationship between the suspected parent’s presence and the child’s medical symptoms. The admission is designed to closely observe and monitor the child’s symptoms in the hospital, assess interactions between the child and the suspected parent, and sometimes to limit or restrict the suspected parent’s contact with the child. Limited visitation by family members is an important element of the hospitalization so that the child’s medical status can be objectively assessed. Such admissions require careful preparation, leadership from the treating physician, and support from hospital administrators. The parent should not be alerted of the suspected MBP abuse. Rather, justification to parents for the planned hospitalization may include assessing treatment efficacy of the child’s current medical regimen or conducting further diagnostic assessment. Of course if the parents do not consent, legal action is required.

*Video surveillance* allows the parent-child interactions in the hospital to be monitored without the parent’s knowledge and may be a helpful strategy in confirming or refuting a MBP diagnosis. Video surveillance can be a helpful element of the planned hospitalization but few hospitals in Michigan have formalized protocols. The medical and legal literature suggests that this procedure may help to protect the child and confirm MBP in cases when the child is felt to be in extreme danger, e.g. from suffocation or other forms of induced symptoms. Video surveillance may help in ambiguous cases where the suspected parent is suspected of fabricating, simulating, or exaggerating the child’s medical symptoms. It may also rule out the diagnosis when the child’s medical condition is observed to be consistent with the suspected parent’s report.<sup>18</sup>

Video surveillance is a delicate area legally and should be approached with some caution. Michigan law prohibits the use of devices for observing, photographing or eavesdropping *in a private place*. MCL 750.539c, MCL 750.539d. Federal law makes it a crime to intercept an oral communication without a court order for a wiretap. Title 18 USC 2511. Hospitals are encouraged to develop their own protocols and policy about surveillance in close consultation with their legal counsel. DHS should consult with the county prosecutor or Attorney General for guidance.<sup>19</sup>

*Temporary Diagnostic Separation* is a third method of evaluating the relationship between the suspected parent's involvement and the child's symptoms. Diagnostic separation is especially helpful in cases involving infants and young children, when exaggeration or fabrication has been chronic, or when there is suspicion of direct induction.<sup>20</sup> Temporary Diagnostic Separation places the child in a safe setting while objective medical and psychological assessment is completed. The safe setting should be a placement in which the suspected parent does not have the ability to have unsupervised contact with the child and does not have the capacity to impact on the daily care and medical treatment of the child. Some commentators urge that the child always be placed in non-relative foster care,<sup>21</sup> but in some carefully controlled circumstances, relative care may be appropriate. For example, placement with extended family may be indicated when the family member can be trusted to cooperate fully with protecting the child from the suspected parent. A diagnostic separation (a) allows for an objective evaluation of the child's medical status, (b) provides an opportunity to obtain a report of the child's symptoms while away from the parent and family, (c) grants the time needed to complete a comprehensive assessment of the parent's psychiatric condition and the family dynamics, and, (d) protects the child from further abuse during the confirmation process. Unless a parent agrees to hospitalization or diagnostic separation, a court order is necessary.

A planned hospitalization, video surveillance or temporary diagnostic separation may provide data and insights that exclude the diagnosis of MBP. When, however, these steps cause the medical team and CPS worker to make a diagnosis of MBP abuse, steps to ensure the child's safety need to be taken immediately. At this juncture, the medical team and the children's protective services worker should notify the parent or legal guardian that abuse is suspected. The child should not be present when the family is confronted and steps to ensure the child's safety need to be in place. Once a diagnosis of MBP abuse is made, the CPS worker and DHS attorney will ordinarily petition the court for jurisdiction and ask to place the child in out-of-home care where the child will be safe. In family court, the medical assessment and report of the medical team and report of the CPS worker becomes a central part of the subsequent child protection legal proceedings.

### **C. OBTAINING MEDICAL RECORDS**

In circumstances where the parents refuse to sign necessary releases of information, DHS can assist in obtaining records from all physicians and institutions that have been involved in the child's medical treatment. Michigan law allows the DHS, in the course of an investigation into suspected child abuse or neglect, to obtain medical records and mental health records without a court order when such records are pertinent to a child abuse or neglect investigation. See Public Health Code, MCL 333.16281(1) and MCL 330.1748a(1). These sections of the law provide that the privileges of physician-patient, dentist-patient, licensed professional counselor-client, limited license counselor-client, psychologist-patient privilege, and any other health care professional-patient privilege created or recognized by law do not apply to medical records or information released by the above sections. These statutes also extend immunity to an individual complying in good faith with the law, unless the conduct was grossly negligent.<sup>22</sup> If records are not released, despite this statutory authority, it may be necessary to seek a court order to obtain them. DHS can assist by seeking a court order to obtain such records. In order for DHS to seek a court order, it must file a child protection petition with the family court.

The legal strength of a child protection case is stronger where the available medical data is such that the physicians feel they can make a diagnosis of MBP. The DHS attorney should discuss the case with the CPS worker and the critical members of the medical team. Ideally the DHS attorney can meet with the CPT and, based on the medical information, provide legal advice as to whether the evidence is sufficient to file a petition and obtain a court order for the remaining medical records, when needed.

Upon the filing of a petition, the court is authorized to order an evaluation of a child by appropriate medical and psychological experts and release of medical records to CPS.<sup>23</sup>

#### **D. COMPREHENSIVE MEDICAL RECORD REVIEW**

An independent, non-treating physician familiar with MBP should complete the comprehensive, retrospective medical record review. The review should include the medical records from all physicians, hospitals, clinics, and laboratories that provided medical treatment to the child. Insurance companies should be contacted to obtain a complete list of all health care providers and also to obtain a list of medications prescribed. Medical records regarding the suspected parent's health seeking behaviors during pregnancy can be useful and review of the accused parent's medical records is also advised because a significant minority of perpetrators fabricates illness in themselves as well as in their children.

The medical record reviewer should first develop a chronology of the child's medical care and then review admission and discharge summaries, consultations, and laboratory findings. The reviewer's second task is to separate medical conditions from suspected, exaggerated, fabricated or induced symptoms. This can be established by determining whether the child's diagnoses were made by laboratory tests and objective information or because the physician(s) gave in to the suspected parent's persistence or relied heavily on the suspected parent's report. The reviewer's third objective is to determine if members of the medical staff have actually witnessed the symptoms reported by the suspected parent. It is recommended that the medical record reviewer contact the treating physician(s) for clarification of symptoms and treatment decisions. The medical record reviewer should also be alert to documented suspicions of pathological health seeking behaviors by treating physicians. The summary of the medical record review can be organized into headings such as Diagnoses With a Basis In Fact, Suspicious Diagnoses, Very Suspicious Diagnoses, and Outright Fabrications/Lies. The summary of the independent medical record reviewer will be important for the court to consider when decisions about the child's placement are made.

#### **E. FORENSIC PSYCHOLOGICAL ASSESSMENT**

When a qualified physician makes a diagnosis of Pediatric Condition Falsification, the next assessment task is to establish the probable explanation of the suspected parent's motivation and determine if the criteria for the psychiatric diagnosis of Factitious Disorder by Proxy (FDP) are met. The specialized psychological assessment may uncover data and insight that rules out MBP and explains the phenomenon in different terms. The psychological assessment could also confirm the diagnosis and provide additional information that could be presented at trial. But the specialized psychological assessment is uniquely important because of the insight it may give to the underlying dynamics that led to the behavior. A thorough psychological understanding of the suspected parent will help guide what treatment and intervention is necessary for family reunification or if the underlying pathology is so severe and irremediable that parental rights ought to be terminated. This psychological assessment should occur after the Preliminary Hearing and before Trial.

If the family does not cooperate, the psychological evaluation should be sought through court intervention and completed by a forensic psychologist serving as the court's expert and not the expert of any of the individual parties. The evaluating psychologist should be experienced in Pediatric Condition Falsification and in Factitious Disorders and should not be part of the medical team that provided treatment to the child. Because the forensic psychological evaluation is court ordered, the usual restrictions of patient confidentiality do not apply and the psychologist needs to obtain information from as many sources as possible. At minimum, the forensic psychologist should have access to the summary of the

medical records review completed by a pediatrician, be authorized to talk with any of the physicians involved in the child's medical treatment, and allowed to review any documents or medical records necessary to complete a comprehensive evaluation. The psychological evaluation should also include an assessment of both parents and interviews with involved extended family such as grandparents. If the child is placed with foster parents, they too should be interviewed. A developmental assessment of young child-victims (<5 years) is needed and a comprehensive psychological assessment of older child-victims is also indicated.<sup>24</sup>

A comprehensive forensic psychological evaluation of Factitious Disorder by Proxy should include an intellectual assessment, personality evaluation and mental status exam of the suspected parent and spouse to first rule out mental retardation and severe mental illness and establish competency. Assessment of the suspected parent's parenting skills and potential for physical abuse is also recommended. Finally, other family members, especially fathers and grandparents, should be separately interviewed to obtain their reactions to the allegations of abuse, inquire about other children in the family, assess the validity of the history provided by the suspected parent, determine the presence of general life stressors, and evidence of collusion with the suspected parent.<sup>25</sup>

The psychologist's second task is to determine if the suspected parent's health seeking behaviors reflect a pattern of behaviors that show s/he persistently and intentionally used the child as an object to meet his or her own self-serving psychological needs. This is accomplished by conducting several individual clinical interviews with the suspected parent and assessing whether the suspected parent persistently and deliberately distorted the child's medical symptoms and deceived the treating physicians into making medical decisions that were significantly influenced by the history (s)he provided. To accomplish this, the psychologist should: (1) compare the level of agreement between the medical history given by the suspected parent to the forensic psychologist with the medical information summarized in the pediatrician's medical record review; (2) determine if the symptoms as reported by the suspected parent were witnessed by the physician, medical staff, or documented in the medical record; (3) assess the suspected parent's reaction to negative test findings; (4) assess the suspected parent's reports of the child's responses to standard treatment; (5) assess the suspected parent's relationships with treating physicians, (6) assess the child's symptoms when separated from the suspected parent, and (7) determine if direct induction of symptoms can be definitively ruled out. The psychologist should also talk directly with the treating physicians to compare their comments/impressions with those provided by the suspected parent. Most importantly, the psychologist needs to determine if the suspected parent accepts any responsibility for the harm done to the child and/or has empathy for the child.

The forensic psychologist's report should detail any discrepancies between the suspected parent's account of the child's medical status and that summarized in the medical record review or provided directly by the treating physicians. The psychologist should also describe any reported or observed differences in the child's medical and psychological status after being separated from the family. The psychologist should comment on whether the suspected parent accepts any responsibility and/or remorse for the child's condition, whether (s)he is amenable to treatment, and whether (s)he continues to fabricate and/or exaggerate the child's medical condition. The psychologist should also comment on the non-offending parent's involvement in the child's medical care, whether there was any collusion with the suspected parent's health seeking behaviors, and if the non-offending parent believes that abuse occurred. The psychological report should make specific recommendations regarding psychiatric/psychological treatment for the suspected parent, non-offending parent and child, detail the criteria for family reunification and to make clear recommendations to the court about the measures needed to monitor the family and protect the child from further harm. Finally, the psychologist should be prepared to testify as a witness at the child protection trial for jurisdiction or at the dispositional hearing or both.

## **PART FOUR**

### **COURT PROCESS**

#### **A. DHS INITIATES THE COURT PROCESS**

DHS caseworkers are responsible for the multidisciplinary coordination throughout the court process. At the point that legal action is necessary to protect the child, the CPS worker should file a petition with the family court. Even though the DHS lawyer and the lawyer-guardian ad litem for the child will be very active in handling the legal proceedings, a large multidisciplinary responsibility will rest with the CPS and foster care workers during this period. Among other things, the workers will provide for the care of the child, supervise any visits, assist the medical record review and arrange the forensic psychological exam. The DHS is required by law and policy to review a child's service plan with the attending physician where MBP is diagnosed.<sup>26</sup>

#### **B. LEGAL REPRESENTATION OF THE PARTIES**

##### **1. Lawyer for the State**

The DHS should be well represented at all stages of court action. Generally, the county prosecuting attorney's office represents the public interest, although the Attorney General's office may appear for the state in some counties. Making the Munchausen by Proxy finding is difficult and complex. Few workers have experience with this form of abuse and careful presentation of factual testimony is critically important. Lawyers for the state should be trained and experienced in Munchausen by Proxy prior to bringing a case to court or should have guidance and supervision from lawyers with expertise in this form of child abuse. These cases are especially complex and difficult to organize so that the DHS representative will need additional time and resources.

##### **2. Lawyer-Guardian ad litem for the Child**

The lawyer-guardian ad litem (L-GAL) for the child should also have experience in representing children and be familiar with the dynamics of Munchausen by Proxy. In the alternative, the L-GAL should have access to and consultation from a lawyer so experienced. The L-GAL is an independent representative of the child and is required by law to carefully investigate the case and come to his or her own determination, based on the evidence and expert opinion.<sup>27</sup>

The L-GAL should carefully follow the mandates of the statute governing the L-GAL role.<sup>28</sup> Existing law gives the L-GAL considerable power to obtain all necessary reports and to consult with various parties. The child's lawyer-guardian ad litem should contact the physicians, psychologists, and other experts and read the reports completed. The L-GAL also has a mandate to try to identify common interests among the parties and promote a cooperative resolution of the case.<sup>29</sup>

If the court takes formal jurisdiction over the child, the dispositional plan is of utmost importance to the L-GAL. The L-GAL should assure that the DHS service plan and court-ordered disposition responds to the dynamics present in the family and is well calculated to maximize the chances of rehabilitation of the family and to allow for safe reunification of the child and the family. On the other hand, the L-GAL needs to carefully assess the facts and expert opinion and pursue termination of parental rights or another permanent plan instead of reunification, where warranted. The child needs a safe and permanent home.

### **3. Lawyer for the Parent(s)**

Suspected MBP cases are extremely difficult for the attorney representing an accused parent. The parent's attorney is the principal protector of the parent's rights where substantial public resources – of the DHS, the prosecutor's office, an array of physicians and other experts – are seemingly amassed against the individual accused parent. The litigation can have profound effects on the parent. They could lose their parental rights temporarily or even permanently. They risk possible criminal prosecution for child abuse where the evidence is clear enough. They may be denied custody of the child for a considerable period of time with all the implications that has for the parent-child relationship. Some parents accused of Munchausen by Proxy genuinely believe that their child is ill and requires the extensive medical treatment that they secured for them. The parents could be concerned that their child is not getting the treatment required when under the control of the state and the court.

The parent's attorney should be experienced in child protection law and should be, or become, knowledgeable about the MBP dynamics. The unusual nature of these cases and the complex fact pattern means that a suspected case of MBP will take more time than many other cases. The lawyer should plan to allocate the necessary time.

A detailed discussion of defense tactics is beyond the scope of this publication, but a few comments are appropriate. If the parent's attorney is involved before a petition is filed or authorized by the court, he or she might evaluate the case and then attempt to find common ground between the parents and the concerned medical professionals in a way that protects the child. Perhaps the parent, seeing the pattern of conduct emerging, is willing to change his or her behavior or to submit to certain conditions that would satisfy child protective services and the medical care providers. Perhaps the non-offending parent or the extended family could be engaged in a way that would protect the child and thus prevent the matter from becoming a formal case.

The parent's attorney should (also) pay careful attention to the experts selected to do the medical record review and the forensic psychological evaluation. DHS and L-GAL may ask that specific professionals be appointed as the court's experts and the parent's attorney will want to be confident that these experts are both knowledgeable and objective. An experienced and knowledgeable expert may be more rigorous and careful in assessing for Munchausen by Proxy because they have seen the phenomenon more often than others and may be able to put the case in a context that is less damaging to the parent. The defense attorney may wish to phone the experts and ask them to describe what will occur in the assessment process and inquire about their experience and training.

The child's placement pending the outcome of the legal proceedings is very important to the parents who probably would prefer placement with a close relative rather than foster care with strangers. Much of the MBP literature recommends against relative care in the belief that if there is a pathological health seeking behavior, the relatives will be less able to resist the influence of the parent (generally the offending parent) or that the emotional dynamics between the offending parent and child will continue. On the other hand, Michigan law and DHS policy encourages relative placement. Parent's counsel might help structure a relative placement such that the DHS, L-GAL and the court are satisfied that the child will be safe.

#### **C. JURISDICTION OVER THE NON-OFFENDING PARENT**

One parent may not know that the other is causing or exaggerating the child's medical condition. Thus, limiting access to the child may violate the non-offending parent's rights unless it is proven s/he

neglected to protect the child or the s/he was in collusion with the offender's pathological health seeking behaviors. Most cases are provable as a parent's failure of due diligence to protect the child's welfare.

If the two parents are members of the same household, the petitioning children's protective services worker can also include in the petition under MCL 712A.2(b)(2) that the "home or environment is unfit" and thus reach both parents. The Michigan Supreme Court has held that even where one parent is blameless in the neglect or abuse of the child, the court may find that the home is unfit, adjudicate the rights of both parents, and take jurisdiction over the child.<sup>30</sup>

#### **D. JURISDICTION OVER SIBLINGS**

Current law allows the court to consider the unfitness of the home environment and take jurisdiction over other children in the family, even when only one child is being targeted.<sup>31</sup> Therefore, the court can look at the safety factors outlined in the Michigan CPS Safety Assessment to determine if other children in the home are safe. In addition, there are several specific criteria that should be considered in assessing the safety of a sibling in a Munchausen by Proxy case including:

- Age – particularly a factor if the sibling(s) are under 5.
- Sibling(s) in the home with chronic medical conditions, developmental disabilities, or a history of medical visits for medical problems that are questionable to the treating physician.
- Multi-faceted abuse, i.e. other forms of child abuse are present.
- Poor school attendance.
- Sibling death in the family.

#### **E. USE THE TEMPLATE OF EXISTING LEGAL PROCESS**

Although MBP may be an unusual form of child abuse, there is no need for special legal procedures to respond to it. The legal response to a diagnosis of MBP is best done using the same template set out in state law for all other types of child maltreatment cases. The short timelines of Michigan law present a challenge to the professionals involved to act promptly and quickly to assess the case and prepare it for presentation to the court. The following is a summary of Michigan's legal process and some recommendations:

##### **1. Preliminary Hearing**

###### **a. Time**

The Preliminary Hearing is the first court appearance in a child protection case and is required within 24 hours of a child being involuntarily detained out of the parents' custody.<sup>32</sup> At the Preliminary Hearing, the petitioner, generally the DHS, must present probable cause to believe that the child is abused or neglected.<sup>33</sup> The physician or physicians should testify at this hearing and spell out the child's medical condition, medical history and the reasoning behind their diagnosis of Munchausen by Proxy.

MCL 712A.2 provides the authority of the family court in child protection cases:

\*\*\*

Sec.2. The court has the following authority and jurisdiction: (b) Jurisdiction in proceedings concerning any child under 18 years of age found within the county whose parents or other person legally responsible for the care and maintenance of the juvenile, when able to do so, neglects or refuses to provide proper or necessary support, education as required by the law, medical, surgical, or other care necessary for his or her health or morals, who is subject to a substantial risk of harm to his or her mental well-being, who is abandoned by his parents, guardian, or other custodian, or who is otherwise without proper custody or guardianship. As used in this sub-subdivision:

(A) "Education" means learning based on an organized educational program that is appropriate, given the age, intelligence, ability, and any psychological limitations of a child, in the subject areas of reading, spelling, mathematics, science, history, civics, writing, and English grammar.

(B) "Without proper custody or guardianship" does not mean a parent has placed the child with another person who is legally responsible for the care and maintenance for the child and who is able to and does provide the child with proper care and maintenance.

(2) Whose home or environment by reason of neglect, cruelty, drunkenness, criminality or depravity on the part of a parent, guardian, nonparent adult, or other custodian, is an unfit place for such juvenile to live in.

### c. Placement

If successful in convincing the court, by probable cause, that the child is abused, the DHS may ask the court to protect the child pending trial by placing the child in an out of home placement. A period of separation, although generally necessary to protect the child from further physical and mental harm, could also serve as a "diagnostic separation" to further confirm the MBP diagnosis.

Michigan law permits the family court to order out of home placement of the child in a protective case after a Preliminary Hearing if the petitioner shows that there is probable cause to believe that the child abuse has occurred and that continued placement with the parents presents a "substantial risk of harm."<sup>34</sup> If a child is to be removed from the parents, Michigan law prefers that the child be

### b. Medical Testimony

Medical testimony at the Preliminary Hearing to authorize the petition and control visits between the parents and child is very important. These are not cases in which a caseworker can appear at the Preliminary Hearing relying on hearsay statements from the doctors. Direct medical testimony is strongly recommended in order to educate and persuade the court of the severity of the child's risk. Medical testimony is best if the physician appears in court, but it could be taken by phone as permitted by Michigan Court Rules. Medical and other records could supplement live testimony. Expert testimony is certainly required to assist the trier of fact to understand the evidence and determine the facts.

It is a clearer legal case at the Preliminary Hearing if the medical expert is able to testify that he or she has already made a diagnosis of Munchausen by Proxy. The doctor should testify to the medical history of the child and draw the inferences from that history. The medical diagnosis of MBP abuse will carry great weight with the court at this stage. As a matter of law, the court is neither obliged to follow the physician's recommendation nor to give decisive weight to the expert opinion. Nonetheless, because the medical diagnosis requires a fairly high level of certainty (although not absolute certainty), informing the court of the factual background and process of coming to that diagnosis will have great weight at the Preliminary Hearing (and later at Trial). The level of certainty behind a medical diagnosis, if clearly communicated to the court, reasonably translates into a least *probable cause* in legal terms.

placed with a relative if consistent with the safety and needs of the child.<sup>35</sup> The safe setting should be a placement in which the parent does not have the ability to have unsupervised contact with the child and does not have the capacity to impact on the daily care and medical treatment of the child. Some commentators urge that the child always be placed in non-relative foster care,<sup>36</sup> but in some carefully controlled circumstances, relative care may be appropriate. The placement, whether relative or non-relative foster care, could include terms and conditions. The DHS worker should be aware that there are reports of intergenerational MBP abuse, so one needs to be very careful with relative placement.

The conditions of placement could include court orders that parental contact be limited and supervised. The court could require that no parental conversation about the child's health occur in the presence of the child, that all medical care be provided through a single medical caregiver, and that the accused parent not be involved in the child's medical care pending trial. Such protective orders may increase the likelihood that relative care could still be protective of the child. If, after a thorough assessment, workers have reason to believe that the relatives can and will control access to the child, relative placement is appropriate. If, after placement, there is good cause to believe relatives have not demonstrated that they are dependable in controlling access, non-relative foster care may be necessary. Another option would be for the court to exclude the accused parent from the home, control his or her access to the child, and leave the child in the custody of the non-offending parent.<sup>37</sup> Because this is such an important issue, it is best determined on a case-by-case basis and the decision based on the potential risk of harm to the specific child.

Where there is concern about parent contact with the child, the DHS might ask that there be no visits or carefully controlled parenting time. Parents are entitled to regular visits (parenting time) with a child in care unless "parenting time, even if supervised, may be harmful."<sup>38</sup>

If the petition is authorized, the court should enter any orders for further investigation, including a psychological examination by a forensic psychologist selected as the court's expert and not an expert for any single party. More commonly, orders appointing an expert and for psychological exam would be considered at a pretrial, but the psychological exam in a MBP case is more complex and will take a longer time to prepare and thus should be ordered at the Preliminary Hearing whenever possible. The lawyers and the court will want the psychological available prior to Trial.

## **2. Pretrial Conference**

Typically the court schedules a Pretrial Conference about three weeks after a Preliminary Hearing. The Pretrial addresses a whole range of technical matters necessary for the case to proceed to Trial. Prompt and diligent action is important to the child and the aggressive timelines of Michigan law will challenge all the professionals involved. Matters such as court orders for discovery, for visitation, for psychological assessment should be handled at the Preliminary Hearing if possible, but could be addressed at Pretrial. Parents have a right to a jury trial and could ask the court to schedule the trial with a jury or before the judge. The trial dates are set at the Pretrial Conference. The Trial is required within 63 days after the child is removed from the home by the court. Typically that is 63 days from the Preliminary Hearing.<sup>39</sup> It may be that the parents will accept the court's jurisdiction without trial and will enter a plea of admission or "no contest" at this time.<sup>40</sup>

## **3. Trial**

The next step in the legal process is to adjudicate the case at Trial by demonstrating the history of invasive or otherwise harmful medical evaluation and/or treatment and psychological harm premised on the accused parent's false or fabricated reports of the child's condition or his or her induction of the

child's symptoms. The testimony at trial should focus on harms suffered by the child due to the parent's conduct. Is this child being abused or not? Presenting the case in the child protection court proceedings as nothing more and nothing less than a child abuse case has more force than trying to persuade a judge about the existence of an abstract syndrome and this case's conformity with it. The court process will test the evidence and reasoning of the professionals. If successful, before a judge or a jury, in proving by preponderance of the evidence that the child is abused or neglected, the case proceeds to the dispositional phase.

#### **4. Dispositional Phase**

A court-ordered disposition depends on a comprehensive, objective forensic psychological assessment of the offending parent, the other parent and the child. The child's medical and psychological needs should also be assessed as a foundation for the court's dispositional order. If the prognosis for rehabilitation is poor, perhaps termination of parental rights is appropriate? Perhaps referral for criminal prosecution is appropriate? If the psychological assessment indicates that rehabilitation of the offending parent is possible, to the point that the child would be safe in his or her custody or in the custody of other family members, a period of appropriate treatment should be pursued with the quarterly court reviews as set out in statute. If rehabilitative efforts are not successful, existing law provides avenues for permanency planning for the child – either in placement with relative caretakers, a guardian, or perhaps termination of parental rights and adoption.

### **PART FIVE**

#### **DISPOSITION AND TREATMENT**

##### **A. DHS FOSTER CARE: TREATMENT PHASE**

The DHS foster care workers are responsible for coordinating activities among all the other professionals during the dispositional phase. Generally the worker should:

- Implement a case plan based on recommendations by the multidisciplinary team of experts and as ordered by the court.
- Ensure continuation of care by medical providers who accept the MBP diagnosis.
- Evaluate, in consultation with the forensic psychologist and other members of the treatment team, whether the home is safe after a MBP finding and a period of treatment. (See Reunification Criteria below.)
- After the child is returned home, monitor his or her safety and condition for a period of time as recommended by the physician or medical provider and forensic psychologist who completed the evaluation.
- If the child cannot be returned safely to his family of origin, pursue an alternative permanent plan, perhaps requiring termination of parental rights and adoption or guardianship with an extended family member.

In some circumstances, the caseworker and the treatment team will recommend seeking termination of parental rights and adoption or some other permanent alternative home for the child at the first dispositional hearing. The parental offenses may be so egregious and the strengths of the perpetrator and extended family so limited, that an attempt at treatment is not warranted. Criminal prosecution may also be appropriate in certain serious cases.

## **B. MENTAL HEALTH PROFESSIONALS PROVIDING TREATMENT**

Decisions regarding family reunification are greatly dependent on treatment outcomes. Therefore, when a diagnosis of Munchausen by Proxy (Pediatric Condition Falsification and Factitious Disorder by Proxy abuse) are confirmed, a well-developed treatment plan for the perpetrator, the child-victim and extended family must be detailed and closely monitored by the court. Specifically, a primary physician should develop a detailed medical treatment plan for the child-victim. When possible, the medical treatment should be provided by the same medical team that identified MBP because it is most familiar with the child's medical condition. If another physician is selected to provide ongoing medical care, that physician needs to accept the MBP abuse finding of the court and be willing to carry out the court's order regarding medical monitoring. Similarly, a treatment plan should be developed and a therapist experienced in child abuse needs to be identified to work with the child-victim.

Treatment for the offending parent will need to include intensive, long term, individual psychotherapy. The therapist should be a mental health professional other than the one who completed the court ordered evaluation and should be initiated after the court has made its final ruling. The therapist should be experienced in the treatment of personality disorders and also must accept the diagnosis of Munchausen by Proxy. The therapist should be given a copy of the medical record review summary and a copy of the psychological evaluation of the offending parent and the non-offending parent. It is also advised that the therapist meet with or consult with the medical treatment team, foster care worker and forensic psychologist to set up the terms of the therapy. The treatment plan should then be presented to the judge for approval. The therapist should communicate regularly with the forensic psychologist who can then choose what is relevant to report to the court regarding treatment compliance and progress when reunification issues are being considered. This process allows the therapist to safeguard the offending parent's confidentiality in areas unrelated to MBP abuse and helps to maintain a trusting therapeutic relationship. However, the therapist is not exempt from mandatory reporting of suspected abuse if concern should surface during treatment.

Therapy for the non-offending parent should focus on helping him or her to accept responsibility for failing to protect the child in the past and to determine if s/he can protect the child in the future if the child is returned to the family. Therapy may also need to address the marital relationship and the impact the MBP diagnosis has had on the marriage.

The determination of reunification versus termination of parental rights should be based on the results and recommendations of a comprehensive psychological re-evaluation of the mother, father, and child following treatment; usually after one year of treatment. Ideally, the same forensic psychologist who completed the original evaluation of the family should complete the re-evaluation. This re-evaluation may yield important supportive data about changes that have occurred in therapy, and provide additional documentation to support that the parent(s) demonstrates decreased denial and defensiveness and is ready for the re-unification process to begin.

Psychological education and support of the extended family is also important in the comprehensive intervention plan for this form of abuse. Before a child is returned home, the extended family should accept that the abuse occurred and agree to protect the child from further medical abuse. If supportive and capable, the alert and educated family may be able to provide the necessary protection that allows the child to be safely reunited with the family.

### C. REUNIFICATION CRITERIA

Reunification should be a thoughtful and progressive process rather than a single act or event and it should only be considered following successful and well-monitored parental treatment. The reunification decision should start with the DHS Reunification Assessment, which has three steps: 1) An assessment of compliance with the parenting time plan; 2) An assessment of primary barriers to reunification and risk reduction; and 3) A determination of the child's safety.<sup>41</sup>

Meadow (1985) identifies several risk factors that may suggest that reunification is contraindicated. They include:

- Abuse involving suffocation and/or poisoning.
- Previous unexplained death of a sibling of the child-victim.
- A parent with Munchausen syndrome.
- Drug abuse or alcoholism.
- Fabrication continues after confrontation.
- Little feasibility of support from extended family.
- Perpetrator has no insight into what has happened.<sup>42</sup>

Schreier and Libow (1993) propose specific criteria that can assist the court in making difficult reunification decisions that are in the best interests of the child and also mindful of parental rights.

- The victimized child does not have any serious, bona fide medical problems that would require complex or extended contact with the medical system after reunification. This could seriously complicate the efforts of monitoring agents to determine if the MBP behavior has resolved.
- The abusing parent has achieved some insight and a meaningful explanatory system for understanding the nature of the abusive behavior and the needs s/he was attempting to meet through the use of the child as proxy.
- The abusive parent has developed some alternative coping strategies to use when under stress and has demonstrated awareness of significant stress factors in his or her own life.
- The perpetrator's spouse, partner, or extended family has accepted the reality of the abusing parent's behavior and demonstrated a sincere commitment to the future protection of the child.
- The abusing parent's therapist, as well as the evaluating forensic psychologist, is in agreement that the parent has made progress during psychotherapy.
- The abusive parent does not exhibit additional serious psychopathology such as a thought disorder, affective disorder, organicity, or the like.
- There is no evidence that the abusive parent continues to claim that the child has unsubstantiated medical problems or that the parent continues to distort facts or somaticize the parent's own problems.
- The abusive parent is able to demonstrate adequate basic parenting skills, genuine warmth for the child, and increased empathic understanding of the child's experiences.
- The . . . court [assures] long-term follow-up of the family's reunification over an extensive period. Follow-up does not simply mean periodic home visits and visual inspection of the child, but also regular communication with the child's physician and school to examine patterns of absence and medical utilization.
- Provisions are in place either for restrictions on the family's ability to move to new jurisdictions or at least a transfer of long-term follow-up responsibilities to educated authorities in new jurisdictions.<sup>43</sup>

Formulating a community protection plan that extends beyond the nuclear family may moderate any risks to the child from reunification. For instance, while the child remains a ward of the court, the power to make medical care decisions could remain with someone other than the offending parent. Extended family members, like the non-offending parent, grandparents, aunts or uncles, could be engaged to help protect the child from further harm. Therapy could continue for a period of time, as could supervision by the DHS.

## **PART SIX**

### **CONCLUSION**

The assessment and diagnosis of Munchausen by Proxy child abuse (Pediatric Condition Falsification/Factitious Disorder by Proxy) is a complex and emotionally charged task. This potentially fatal form of child abuse requires the most current data and expertise to protect the child's physical and psychological safety. Health care providers, child protection agencies, and the legal profession must appreciate the special issues involved in this form of child abuse. This document is designed to assist the various professionals in the interdisciplinary collaboration necessary to successful management of cases where pathological health seeking behavior is suspected.

- <sup>1</sup> Schreier, H. A. & Libow, J.A. (1993). *Hurting For Love*, New York: Guilford Press;
- Parnell, T.F. (1998). An overview. In T.F. Parnell & D. O. Day (Eds.) *Munchausen by Proxy Syndrome: Misunderstood Child Abuse* (pp. 3-8). Thousand Oaks: Sage Publications.
- <sup>2</sup> APSAC Advisor, Spring 1998
- <sup>3</sup> Id. See also the Diagnostic and Statistical Manual IV at p. 682.
- <sup>4</sup> APSAC Advisor, Spring 1998 See also the Diagnostic and Statistical Manual IV at p. 475.
- <sup>5</sup> APSAC Advisor, Spring 1998
- <sup>6</sup> Fisher, G. (1995). Etiological Speculations. In A.V. Levin & M. Sheridan (Eds), *Munchausen Syndrome by Proxy: Issues in Diagnosis and Treatment* (pp. 39-58). New York: Lexington
- <sup>7</sup> M. Sheridan (In Press) *The Deceit Continues: An Update Literature Review of Munchausen Syndrome by Proxy. Child Abuse and Neglect*. Four hundred fifty-one cases of MBP were analyzed from 154 medical and psychosocial journal articles. Six percent of victims were dead. Twenty-five percent of victim's known siblings are dead.
- <sup>8</sup> Parnell, T.F. (1998). Defining Munchausen by Proxy Syndrome. In T.F. Parnell & D.O. Day (Eds), *Munchausen by Proxy Syndrome: Misunderstood Child Abuse* (pp. 9-46). Thousand Oaks, CA: Sage
- <sup>9</sup> McClure, Davis, Meadow & Sibert (1996). Epidemiology of Munchausen Syndrome by Proxy, Non-accidental poisoning, and Non-accidental Suffocation. *Archives of Diseases in Childhood*, 75, 57-61.
- <sup>10</sup> (Schreier, 1997); APSAC Advisor, Spring 1998.
- <sup>11</sup> Parnell, T. F. (1998). Guidelines for Identifying Cases. In T. F. Parnell & D. O. Day (Eds), *Munchausen by Proxy Syndrome: Misunderstood Child Abuse* (pp 47-67). Thousand Oaks, CA: Sage.
- <sup>12</sup> Michigan Child Protection Law, MCL 722.623
- <sup>13</sup> Child Protective Services is required to seek assistance of and cooperate with law enforcement officials pursuant to MCL 728(3) and DHS Policy.
- <sup>14</sup> Michigan Child Protection Law, MCL 722.628(8)
- <sup>15</sup> Michigan Child Protection Law, MCL 722.628(3)(c)
- <sup>16</sup> Michigan Child Protection Law, MCL 722.625
- <sup>17</sup> Seibel and Parnell (1998), The Physician's Role in Confirming the Diagnosis. In T.F. Parnell & D.O. Day (Eds), *Munchausen by Proxy Syndrome: Misunderstood Child Abuse* (pp 68 - 94). Thousand Oaks, CA: Sage.
- <sup>18</sup> Hall, Eubanks, Meyyazhagan, Kenney and Johnson, *Evaluation of Covert Video Surveillance in the Diagnosis of Munchausen Syndrome by Proxy: Lessons from 41 Cases*, 105 PEDIATRICS 1305-1312 (June 6, 2000);
- <sup>19</sup> The following authorities are provided to assist legal advisors as they make more specific recommendations. A general patient consent is a possible basis for authorizing video surveillance. That is the approach used by Scottish Rite Hospital in Atlanta. (Hall, et. al. *Evaluation of Covert Video Surveillance in the Diagnosis of Munchausen Syndrome by Proxy: Lessons from 41 Cases*, 105 PEDIATRICS 1305-1312 (June 6, 2000). Several courts have found that an expectation of privacy in a hospital room is not reasonable. (*People v. Courts*, 205 Mich App 326 (1994); *Buchanan v. State* 432 So 2d 147 (Fla Dist. Ct. App. 1983); See Beatrice Cross Yorker, *Covert Video Surveillance of Munchausen Syndrome by Proxy: The Exigent Circumstances Exception*, 5 Health Matrix J. L-Med 325 (1995); But see Flannery, *First Do No Harm: The Use of Covert Video Surveillance To Detect Munchausen Syndrome by Proxy An Unethical Means of "Preventing" Child Abuse*, 23 U. Mich. J.L.Ref. 105 (Fall 1998).) Note, however, that Michigan law prohibits the use of devices for observing, photographing or eavesdropping *in a private place*. MCL 750.539c, MCL 750.539d. Federal law makes it a crime to intercept an oral communication without a court order for a wiretap. Title 18 USC 2511. Legal advisors should also be aware of the distinction between video surveillance for purposes of medical diagnosis or child protection versus its use for law enforcement or criminal prosecution. See *Ferguson et. al. v. City of Charleston et. al.*, 532 U.S.67 (2001) in which the U.S. Supreme Court held that a state hospital's performance of a diagnostic drug screening test to mothers who have just given birth in order to obtain evidence of their criminal conduct for law enforcement purposes, and not for a special need beneficial to the child or parent, is an unreasonable search if the patient has not consented to the procedure. See also Yorker op cit.
- <sup>20</sup> Kinscherff, R., & Famularo, R. (1991). Extreme Munchausen syndrome by Proxy: The case for Termination of Parental Rights. *Juvenile and Family Court Journal*, 40, 51-53
- <sup>21</sup> Parnell, T. F. (1998). Coordinated Case Management Through the Child Protection System. In T. F. Parnell & D. O. Day (Eds), *Munchausen by Proxy Syndrome: Misunderstood Child Abuse* (pp 95-116). Thousand Oaks, CA: Sage.
- <sup>22</sup> See also, *Michigan Child Welfare Law*, page 250, available on line at [http://www.michigan.gov/documents/MCWLChap16\\_34824\\_7.pdf](http://www.michigan.gov/documents/MCWLChap16_34824_7.pdf)
- <sup>23</sup> MCL 712A.12, MCR 5.923
- <sup>24</sup> Day, D. O., & Ojeda-Castro, M.D. Therapy with Family Members. In T. F. Parnell & D. O. Day (Eds), *Munchausen by Proxy Syndrome: Misunderstood Child Abuse* (pp 202-218). Thousand Oaks, CA: Sage
- <sup>25</sup> Griffin, J. L. (1988). The Family System of Munchausen Syndrome by Proxy. *Family Process*, 27, 423-437.

<sup>26</sup> MCL 712A.18f(6); DHS Children's Foster Care Manual, CFF 722-6

<sup>27</sup> MCL 712A.17d

<sup>28</sup> MCL 712A.17d

<sup>29</sup> MCL 721A.17d(j)

<sup>30</sup> The Michigan Supreme Court held in *In re Jacobs*, 433 Mich 24 (1989), that the court may find the home environment unfit and take jurisdiction over a child without finding that the parent is to blame for the unfitness. The parent who is not actively abusing or neglecting the child is afforded due process in that he or she has the opportunity to refute evidence that the home environment is unfit. See also *In the Matter of CR, CDR, ALR, and LB, Minors*, Mich. App. (2002) (COA No. 228856) in which the Court of Appeals held that the family court's jurisdiction is tied to the child and may enter orders of protection and disposition even without a finding against both parents.

<sup>31</sup> *In re Dittrick*, 80 Mich App 219 (1977); *In the Matter of LaFlure*, 48 Mich App 377 (1973).

<sup>32</sup> MCR 5.965(A)

<sup>33</sup> MCL 712A.13a(2)

<sup>34</sup> MCR 5.965(C)

<sup>35</sup> MRC 5.967(C)(4)

<sup>36</sup> Parnell, T. F. (1998). Coordinated Case Management Through the Child Protection System. In T. F. Parnell & D. O. Day (Eds), *Munchausen by Proxy Syndrome: Misunderstood Child Abuse* (pp 95-116). Thousand Oaks, CA: Sage.

<sup>37</sup> MCL 712A.13a(4)

<sup>38</sup> MCL 712A.13a(11)

<sup>39</sup> MCR 5.972(A) Trial is required within 6 months if the child is not in placement.

<sup>40</sup> MCR 5.971

<sup>41</sup> DHS Children's Foster Care Manual, CFF 722-9A.

<sup>42</sup> Meadow (1985)

<sup>43</sup> Schreier and Libow (1993)

## Selected References

- Abdulhamid, I., Siegel, P.T. (2002) The other face of child abuse: Munchausen by proxy. E-Medicine, World Medical Library.
- Ayoub C.; Alexander R.; Beck D.; Feldman K.; Libow J.; Sanders M.; Schreier H.; Yorker B. Position Paper: Definitional Issues in Munchausen by Proxy. *Child Maltreatment*, Vol. 7, #2, 105-111, May 2002.
- Bryk M., Siegel P. My Mother Made Me Sick: The Story of an Adult Victim of Munchausen By Proxy Syndrome. *Pediatrics*, Vol. 100#1, pp. 1-7, July, 1997.
- Day, D. O. & Parnell, T. F. (Eds.). *Munchausen by proxy syndrome: Misunderstood child abuse*. Thousand Oaks: Sage Publications, 1998.
- Kinscherff, R., & Famularo, R. (1991). Extreme Munchausen syndrome by proxy: The case for termination of parental rights. *Juvenile and Family Court Journal*, 40, 41-53
- A. L. Levin & M. S. Sheridan (Eds.). *Munchausen syndrome by proxy: Issues in diagnosis and treatment*. New York: Lexington Books, 1995.
- Rosenberg. D. (1994). Munchausen syndrome by proxy. In R. M. Reece (Ed.), *Child abuse-Medical diagnosis and management* (pp. 266-278). Philadelphia: Lea & Febiger.
- Rosenberg. D. (1997). Munchausen Syndrome by Proxy: Currency in Counterfeit Illness. In A. E. Helfer, R. S. Kempe, R. D. Krugman (Eds.), *The battered child: fifth edition* (pp. 413-430). Chicago: University of Chicago Press.
- Schreier, H. A. & Libow, J. A. (1993). Hurting for love. pp. 218-219. New York: Guilford Press.
- Siegel P.T., Fischer H. (01/01). Munchausen by proxy syndrome: barriers to detection, confirmation, and intervention. *Children's Services: Social Policy, Research, and Practice*, 4(1), 31-50.



Quantity: -0-

Cost: -0-

Authorization: DHS Director

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

WEB ONLY

DHS-PUB-17 (Rev. 6-07)